STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155694	A. BUILDING _____ B. WING _____	03/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETZ NURSING HOME	116 BETZ RD AUBURN, IN46706

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F0000	This visit was for the investigation of Complaint Number IN00086188. Complaint Number IN00086188 unsubstantiated due to lack of evidence. Unrelated deficiency cited Survey dates: February 28, 2011 and March 1, 2011 Facility number: 000306 Provider number: 155694 Aim number: 100273860 Survey team: Ann Armey, RN TC Diane Nilson, RN Census bed type: SNF/NF: 92 Total: 92	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census payor type: Medicare: 13 Medicaid: 47 Other: 32 Total: 92 Sample: 5 This deficiency also reflects State Findings in accordance with 410 IAC 16.2. Quality review completed 3-2-11 Cathy Emswiller RN			

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F0323 SS=G	Based on observation, interviews and record review, the facility failed to provide supervision and implement interventions to prevent a confused resident from falling out of bed. This deficient practice resulted in a fall with an abrasions and a hematoma and affected 1 of 3 residents reviewed, who sustained falls, in a sample of 5. (Resident #F) Findings include: The closed clinical record of Resident #F was reviewed on 3/1/11 at 9:30 a.m. and indicated the resident was admitted to the facility on 2/2/11 following treatment at the hospital for a closed head injury. The hospital admission history and physical, dated 1/28/11, indicated Resident #F was admitted to the hospital after a fall. The report indicated the resident was working on a shelf at home and fell hitting his head in the right temporal region and then fell again hitting the right occipital region of the head sustaining a closed head injury. A consultation report, dated 1/28/11. indicated the resident had an abnormal CT (Computed Tomography) Scan, "question intracranial hemorrhage versus mass."	F0323	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after March 31, 2011.The facility requests an Informal Dispute Resolution for deletion or reduction of F 323**F 323 Accidents** It is the practice of this provider to ensure that resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.**This tag is being disputedWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Residents at risk for falls have the potential to be affected by the alleged deficient practice. Staff has been re educated on the fall program by the DNS/designee by 3/31/11. **What measures will be put into place or what systemic**	03/31/2011

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	A nursing admission assessment, dated 2/2/11, identified no discolorations or swelling on Resident #F's head. The interim admission nursing care plan, dated 2/2/11, indicated Resident #F was at risk of falls. The care plan indicated, in part, the following: Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait; Encourage and remind to use call light; Refer to therapy for screening; Provide assistance for transfers, bed mobility; Fall risk assessment; Provide appropriate assistive devices such as walker, low bed, mats on floor, alarms on chairs/bed. The fall risk assessment, dated 2/3/11, indicated the resident had fall risk factors, including; a history of falls, anti-hypertensive medications, evidence of impaired gait and confusion. The medication administration record for February 2011, indicated the resident was to have a canary alarm on for seven days starting on 2/2/11. One half side rails for mobility, physical therapy, speech therapy and occupational		**changes you will make to ensure that the deficient practice does not recur?** Staff has been re educated on the fall program by the DNS/designee by 3/31/11. A fall risk assessment will be completed upon admission, quarterly, and with a resident's change in condition. Fall risk assessment will be reviewed at least quarterly. Fall interventions will be placed upon determination of fall risk. This includes upon admission, quarterly, annually and with significant change. Fall interventions will be addressed on the C.N.A. assignment sheet and the resident's care plan. Falls will be reviewed daily in the morning meeting Mon-Fri excluding holidays. Fall circumstance will be completed to determine root cause analysis of resident's falls. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** **Data will be submitted to the CQI committee for review and follow up.** **The Executive Director and / or designee will be responsible for program compliance** **Compliance date: 3/31/11** A fall and fall prevention CQI tool	

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	therapy were ordered on 2/3/11. Nursing notes indicated the following: On 2/5/11 at 12:00 midnight, Resident #F was trying to climb out of bed causing his alarm to sound. The note indicated the resident's gait was unsteady and he was answering questions inappropriately. On 2/6/11 at 10:40 p.m., Resident #F was pulling the call light out and standing up setting off the canary alarm. The note indicated the alarm was sounding and when the writer entered the room the resident was sitting on the side of the bed attempting to stand and was very confused. The resident's glasses were noted to be broken into pieces and he was taken to the lounge to be monitored because he kept setting off his alarm and trying to get up. The note indicated "Res (Resident) also has started new medication @ (at) 8p Ativan (a medication used for anxiety) 1 mg tonight..." On 2/7/11 at 2:15 a.m., Resident #F's "...canary going off again. This has been an ongoing issue all night. Res (resident) found on floor. Res has climbed out of bed again setting off alarm et (and) fell on floor hitting head with small lump noted to crown. Res also has 5 in by 1 in		will be utilized weekly times 4, monthly times 2, then quarterly thereafter. Resident #F no longer resides in the facility.3/23/11 Addendum to the POC:Fall assessments are completed upon admission, quarterly and with any significant change to determine which intervention can ensure the residents safety in our facility. A fall intervention list has been supplied to each unit for the charge nurses to reference when there is a possible/need that could occur. Nursing staff have been in-serviced on Falls / safety and to be proactive with the residents that are showing signs of confusion, agitation and unsafe behaviors. New Admission assessments are being examined for potential problems with falls and the admission team is being proactive with assessing for potential problems; talking to family members prior to admission. The team then determines what proper equipment should be in place prior to admission. Staff continues to call the DNS with all falls to review and assure the best intervention is put into place fitting that residents needs. Unit Managers will make daily rounds checking with staff for potential problems with the residents making them a fall risk, and then bringing to the morning meeting to discuss with the IDT team.	

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	abrasion noted to right upper back area..." The nursing note indicated Resident #F was placed in the wheelchair and taken to the lounge for observation. A neurological assessment log was initiated. The fall circumstances report, dated 2/7/11, indicated the resident fell on 2/7/11 at 1:50 a.m. The report indicated Resident #F was found in his room sitting on the floor with the canary alarm sounding. The report further indicated the resident climbed out of bed and hit his head. The report indicated the resident had an abrasion on his back, a scratch on the elbow, and a "small goose egg to crown of head." The resident's CQI (Quality Improvement) incident reporting slip, dated 2/7/11, indicated the resident's functional level at the time of the fall was "extensive assistance" and "totally dependent." On 2/7/11 at 11:30 a.m., a low bed and floor mat were ordered. Although Resident #F had a care plan to implement appropriate assistive devices, including but not limited to, low bed and floor mat and was noted to be climbing out of bed unassisted on 2/5/11 and 2/6/11, the low bed and floor mat were not ordered or implemented until after the		CNA assignment sheets are updated accordingly; with updated interventions regarding the residents ADL's.	

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	resident fell. On 3/1/11 at 11:30 a.m., The Director of Nursing was interviewed and indicated the low bed and floor mat were not implemented until after the fall. On 3/1/11 at 2:40 p.m., LPN #10, who worked on the evening shift on 2/6/11 and the night shift on 2/7/11 when the resident fell, was interviewed and indicated Resident #F was in the lounge earlier in the evening so he could be watched but was returned to his bed about an hour before he fell. LPN #10 indicated she was assisting the aide with rounds on the 200 hall of the west wing. The LPN indicated the aide heard an alarm sounding and found Resident #F on the floor. LPN #10 indicated the resident told her he hit his head. The nurse did not measure the bump on the head. She indicated the resident was in a standard bed (in a low position) and did not have a low bed until after the fall. On 3/1/11 at 3:00 p.m., Resident F's room (102) was observed. The resident's room was on a different hall and was not visible from the 200 hall where the nurse and aide were working when the resident fell.			

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	On 3/1/11 at 3:50 p.m., CNA #11, who was working on the night shift when Resident #F fell was interviewed. CNA #11 indicated she and the nurse were on the floor assisting a resident on the 200 hall and after they finished assisting the resident, they came out of the room and heard the alarm sounding. CNA #11 indicated she ran to the 100 hall because she was not sure how long the alarm had been sounding and found the resident sitting on the floor. On 3/1/11 at 4:15 p.m., CNA #12 who worked on Resident #F's hall on the evening of 2/6/11, was interviewed and indicated Resident #F was repeatedly attempting to get out of bed so the nurse brought him to the lounge. She indicated she sat with the resident in the lounge for about one-half hour until she went home at 10:00 p.m. She indicated she told the oncoming night shift staff that the resident was agitated, attempting to get up and needed to be watched. On 2/8/11, physician progress notes indicated the resident had become unresponsive and indicated the resident had a "probable new CVA (cerebral vascular accident)." On 2/8/11, comfort measures were ordered.			

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	On 2/12/11 at 6:15 a.m., nursing notes indicated Resident #F expired in the facility. The death certificated listed the cause of death as "cerebrovascular accident." The Fall Management Program, revised 3/10, provided by the Director of Nursing was reviewed on 3/1/11 4:30 p.m. and indicated "It is the policy of American Senior Communities to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychological guidelines to prevent injury related to falls..." 3.1-45(a)(2)			